

COMPLETING THE INTERMITTENT EMPLOYEES GROUP
NJ STATE HEALTH BENEFITS PROGRAM APPLICATION

QUICK REFERENCE

- This application is for use by intermittent State employees who are eligible for State Health Benefits Program coverage. For more information about this coverage and the eligibility requirements for intermittent employees, see Fact Sheet #69, *SHBP Coverage for State Intermittent Employees*.
- **To change your primary care physician (PCP)** with NJ PLUS, contact Horizon Blue Cross Blue Shield directly at: 1-800-414-SHBP. **DO NOT COMPLETE THIS FORM JUST TO CHANGE YOUR PRIMARY CARE PHYSICIAN.**
- To **enroll** for the first time complete all sections of the application with the exception of section 5.
- To **change coverage level** (adding/deleting dependents) complete sections: 1, 2a, 2b, and 2c (if applicable), 4, (be sure to list **all** eligible dependents), 5 (listing why you are changing coverage level), and 6.
- To **add a dependent** complete sections: 1, 2a, and (as applicable) 2b and/or 2c, 4 (list all eligible dependents), 5a, and 6.
- To **terminate/decline coverage** complete sections: 1, and either 2a and 2b to terminate/decline prescription drug coverage only, **or** 2a and 2c to terminate/decline NJ PLUS coverage only, **or** 3 to waive **all** coverage, and 6. Note: If you are declining enrollment for yourself or any or all of your eligible dependents because of other group health insurance coverage, you may in the future be able to enroll yourself and/or your eligible dependents in a SHBP medical plan, provided that you request enrollment within 60 days after your other group health coverage ends.

SECTION 1 — EMPLOYEE INFORMATION

This section must be completed in its entirety each time an application is submitted. The employee enrolling or enrolled in the plan completes this section.

SECTION 2 — MEDICAL COVERAGE

- 2a. Check only one box** indicating if you want NJ PLUS **and** Prescription Drug Plan coverage, NJ PLUS coverage **only**, or Prescription Drug Plan coverage **only**. If selecting NJ PLUS coverage, be sure to provide your NJ PLUS Primary Care Physician's ID number. Refer to the NJ PLUS directory for this information or call NJ PLUS at 1-800-414-SHBP.
- 2b.** If you are selecting NJ PLUS coverage, check the NJ PLUS coverage level desired.
- 2c.** If you are selecting prescription drug coverage, check the Prescription Drug Plan coverage level desired.

Note: A Domestic Partner is defined for eligibility in the SHBP, by Chapter 246, P.L. 2003, as a person of the same sex to whom you have entered into a domestic partnership and received a *Certificate of Domestic Partnership* from the State of New Jersey (or a valid certification from another jurisdiction that recognizes same-sex domestic partners, civil unions, or similar same-sex relationships). If covering a Domestic Partner as a dependent, you must attach a photocopy of the *Certificate of Domestic Partnership* to this application.

SECTION 3 — WAIVER OF COVERAGE

If you do **not want to be covered** under any health or prescription drug plan, check this box. Note: Once you decline or cancel coverage, enrollment is not normally permissible until the next open enrollment period or if other coverage is lost and proof of loss is provided (HIPAA).

SECTION 4 — DEPENDENT INFORMATION

Only eligible dependents may be listed. Completion of this section is essential for proper enrollment. Be sure dependents listed agree with the level of coverage selected in sections 2b and 2c. List the name, date of birth, gender, and Social Security number of the family members you wish to be covered under the plan. An eligible spouse is an individual to whom you are legally married. An eligible domestic partner is an individual of the same-sex with whom you have entered into a domestic partnership (see note in instructions for Section 2, above). If you have listed a child that is a foster child, stepchild, legal ward, or has a different last name than the employee, proof of dependency is required (contact your payroll/personnel representative for an SHBP *Affidavit of Dependency* form). If you have more than 4 eligible dependent children, attach a separate application and complete Sections 1, 4, and 6. For all dependents, include the NJ PLUS Primary Care Physician identification number. All dependents must have this information listed. Refer to the NJ PLUS directory for this information or call NJ PLUS at 1-800-414-SHBP.

Note: If you are deleting dependents, do not list them in this section. Refer to section 5b and 5c.

SECTION 5 — TYPE OF ACTIVITY

- 5a.** If you are adding a dependent, check the appropriate box and the event date.
- 5b.** If you are deleting a dependent spouse or domestic partner, check reason and indicate the event date.
- 5c.** If you are deleting a dependent child, indicate the event date, list the child's Social Security number, and give reason.
- 5d.** For other changes, check the appropriate box and give reason.

SECTION 6 — EMPLOYEE CERTIFICATION

You must read the Employee Certification statement, **sign it, and date the application**.
Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

EMPLOYER CERTIFICATION

- Must be completed by your employer.** This application must be certified by the employer before submitting it to the SHBP. The Certifying Officer should:
- 1) Verify the employee's eligibility;
 - 2) Verify that the application is legible and completed in its entirety;
 - 3) Verify that the employee's selected plans and coverage levels are appropriate; and
 - 4) Complete the Employer Certification section in its entirety.